Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STAEC
2622 MARINA BAY DR
LEAGUE CITY TX 77598

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-1357-01

MFDR Date Received

JANUARY 3, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is my letter for reconsideration for payment. Services rendered were done emergently per surgeon Dr. Charles Polsen. Patient's initial surgery was 03-12-08 where his right pinky was amputated. This claim in question was scar tissue surrounding his nerves; patient was in severe and intense pain, so severe patient was crying uncontrollably thru out the day. Surgeon made him N.P.O and was placed on his emergently surgery list on 9-8-11."

Amount in Dispute: $800.00*

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided outpatient emergency room and anesthesia services associated with a surgical procedure to the claimant 9/8/11 and then billed Texas Mutual codes 26440 & 01810. Rule 134.600 at (p)(2) states that outpatient surgical or ambulatory surgical series require preauthorization unless the services are emergent. Rule 133.2 at (3)(A) defines a medical emergency as the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: ()1) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part. The requestor's documentation does not substantiate that the claimant's report of pain was related to a serious dysfunction of any body organ or par, or that waiting for the preauthorization decision would have placed the claimant's health or bodily functions in serious jeopardy. Absent such documentation the requestor provided surgical treatment without the requisite authorization. No payment is due."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2011	CPT Code 26440 x 2 Codes withdrawn by Angela with Dr. Polsen's office	$3,487.28	$0.00
September 8, 2011	CPT Code 01810	$800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out the guidelines for ambulatory surgical centers.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1 – Workers Compensation State Fee Schedule adjustment.
   - 16 – Claim/service lacks information which is ne3eded for adjudication. At least one remark code must be provided (may be comprised of either the remittance advice remark code or NCPDP reject reason cod.)
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 197 – Precertification/authorization/notification absent.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 785 – Service rendered is integral to service requiring preauthorization. Preauthorization not sought/approval not obtained for that service.
   - 891 – No additional payment after reconsideration.
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT Code descriptions/instructions.
   - 930 – Pre-authorization required, reimbursement denied.

Issues

1. *Did the requestors' agent, Angela, withdraw the two units of CPT Code 26440?
2. Did the requestor improperly bill for anesthesia services in an ASC setting?
3. Is the requestor entitled to reimbursement?

Findings

1. *A call was placed to the requestor's office and CPT Code 26440, 2 units, was withdrawn from the medical fee dispute. Therefore, this CPT code will not be reviewed; and the amount in dispute is now $800.00 for the disputed anesthesia services.
2. Per 28 Texas Administrative Code §§134.402(d) for coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section. Review of the Medicare payment policy finds that materials, including supplies and equipment for the administration and monitoring of anesthesia; and supervision of the services of an anesthetist by the operating surgeon fall within the scope of ASC facility services, and payment is packaged into the ASC payment for the covered surgical procedure.
3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for anesthesia services.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 17, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.